

## 1915(i) State plan Home- and Community-Based Services Administration and Operation

The State implements the optional 1915(i) State plan Home- and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

**1. Services.** *(Specify the State's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Available service array will be tailored to target group needs, as follows:

**Individuals who are Visually Impaired:**

- Employment Navigator
- Financial Coaching Plus
- Benefits Counseling
- Non-Medical Transportation
- Orientation, Mobility, and Assistive Technology

**Individuals with Physical Disabilities, Intellectual Disabilities, Autism Spectrum Disorders, and/or Asperger's Syndrome:**

- Employment Navigator
- Career Exploration and Assessment
- Small Group Supported Employment
- Individual Supported Employment
- Personal Care (including option for self-direction)
- Benefits Counseling
- Financial Coaching Plus
- Non-Medical Transportation
- Orientation, Mobility, and Assistive Technology

*This 1915(i) SPA, known as Pathways to Employment, will run concurrently with the State's approved 1115 demonstration for the purposes of limiting providers for Employment Navigator and Transportation services.*

*Delaware has been selected to participate in the Employment Resources Refinancing Initiative, an opportunity provided by the United States Department of Labor's Office of Disability Employment Policy, promoting cross-systems change focused on integrated employment outcomes and increased employment options for citizens with disabilities. Pathways to Employment will serve as a key focal point for this initiative, as well as an important part of Delaware's Employment First Initiative.*

**2. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit.** *(Select one):*

<input type="radio"/>	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program ( <i>select one</i> ):	
<input type="radio"/>	The Medical Assistance Unit ( <i>name of unit</i> ):	
<input checked="" type="radio"/>	Another division/unit within the SMA that is separate from the Medical Assistance Unit ( <i>name of division/unit</i> ) <i>This includes administrations/divisions under the umbrella agency that have been identified as the Single SMA.</i>	The benefit will be jointly administered by the following Divisions within the Delaware Department of Health and Social Services, the Single State Medicaid Agency: <ul style="list-style-type: none"> <li>• Developmental Disabilities Services</li> <li>• Aging and Adults with Physical Disabilities</li> <li>• Visually Impaired</li> </ul>
<input type="radio"/>	The State plan HCBS benefit is operated by ( <i>name of agency</i> )	
	A separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules, and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

### 3. Distribution of State Plan HCBS Operational and Administrative Functions.

- ☒ (By checking this box the State assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations. Furthermore, the Medicaid agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(Check all agencies and/or entities that perform each function):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 State plan HCBS enrollment managed against approved limits, if any	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Eligibility evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Review of participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Prior authorization of State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Utilization management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8 Execution of Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

9 Establishment of a consistent rate methodology for each State plan HCBS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Rules, policies, procedures, and information development governing the State plan HCBS benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

For items 7 and 8 above, Delaware contracts with a provider relations agent to perform specific administrative functions. Specific functions by this contractor include the ongoing enrollment of service providers, execution of the Medicaid provider agreement, and the verification of provider licensure, where applicable, on an annual basis.

Provider relations functions include:

- enrolling service providers
- executing provider agreements
- verifying provider licensure/certification on an annual basis

For participant directed services, the contracted Fiscal Management entity will execute and hold provider agreements for providers employed by the individual receiving services.

(By checking the following boxes, the State assures that):

**4. X Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care (POC). Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the State, when providers are given responsibility to perform assessments and POC because such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. (If the State chooses this option, specify the conflict of interest protections the State will implement):

Persons performing evaluations, assessments, and conducting plan of care development are free from conflict as described above. These functions will be performed by Employment Navigators. The providers of this service will be state staff.

In very limited instances, the Division for the Visually Impaired (DVI) may provide direct services that individuals may access through this benefit. In these instances, DVI is among other willing and the qualified provider, but provides the service to ensure access throughout the state.

In all instances in DVI when this may occur, Delaware will establish administrative separation between those doing the assessments and service planning and those delivering direct services. The individuals performing functions related to evaluations, assessments, and POC will be different individuals within

the organization, in different components within DVI, reporting through different lines of operational authority within the Division. The specific lines of authority will be specified in a firewall's document, to be overseen by the Division of Medicaid and Medical Assistance. This document is available for review upon request.

In addition to these administrative conflict mitigation strategies, the State will:

- Assure that individuals can advocate for themselves or have an advocate present in planning meetings
- document that the individual has been offered choices among all qualified providers of direct services
- establish a consumer council within the organization to monitor issues of choice
- establish clear, well-publicized, and easily accessible means for consumers to make complaints and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes
- document the number and types of appeals and the decisions regarding complaints and/or appeals and timeframes for resolution
- have State quality management staff, through targeted sampling strategies, oversee providers to assure consumer choice and control are not compromised

In addition, beginning in the second year of the program, the State will utilize consumer experience surveys to gauge satisfaction with services, including their ability to choose among all willing and qualified providers.

5. ☒ **Fair Hearings and Appeals.** The State assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.
6. ☒ **No FFP for Room and Board.** The State has methodology to prevent claims for FFP for room and board in State plan HCBS.
7. ☒ **Non-duplication of Services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

## Number Served

### 1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	July 1, 2014	June 30, 2015	345
Year 2	July 1, 2015	June 30, 2016	429
Year 3	July 1, 2016	June 30, 2017	430
Year 4	July 1, 2017	June 30, 2018	430

Year 5	July 1, 2018	June 30, 2019	430
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2. ☒ **Annual Reporting.** *(By checking this box, the State agrees to):* Annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

## Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box, the State assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act.)

2. **Income Limits.**

- ☐ In addition to providing State plan HCBS to individuals described in item 1 above, the State is **also** covering the optional categorically needy eligibility group of individuals under 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) or who are eligible for HCBS under a waiver approved for the State under section 1915(c), (d), (e), or Section 1115 to provide such services to individuals whose income does not exceed 300% of the supplemental security income (SSI) federal benefit rate (FBR). *(Select one):*

☐ The State covers all of the individuals described in item 2(a) and (b) as described below. *(Complete 2(a) and 2(b))*

☐ The State covers only the following group of individuals described below. *(Complete 2(a) or 2(b))*

2. (a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria for the 1915(i) benefit, have income that does not exceed 150% of the FPL, and will receive 1915(i) State plan HCBS.

Methodology used *(Select one)*: ☐ AFDC  
☐ SSI  
☐ OTHER *(Describe)*:

For States that have elected the AFDC or the SSI methodology, the State uses the following less restrictive 1902(r)(2) income disregards for this group. There is no resource test for this group. *(Specify)*:

- 2.(b) ☐ Individuals who are eligible for HCBS under a waiver approved for the State under section 1915(c), (d), (e), or Section 1115 to provide such services to individuals whose income does not exceed 300% of the SSI FBR. For individuals eligible for 1915(c), (d), or (e) waiver services, this amount must be the same amount as the income standard specified under your State plan for the special income level group. For individuals eligible for 1915(c)-like services under an approved 1115, this amount must be the same as the amount of the income standard used for individuals found eligible using institutional eligibility rules. *(Select one)*:

☐ 300% of the SSI/FBR  
☐ *(Specify)* \_\_\_% Less than 300% of the SSI/FBR

*(Select one):*

☐ Specify the 1915(c) waiver/waivers CMS base control number/numbers for which the individual would be eligible: \_\_\_\_\_

☐ Specify the name(s) or number(s) of the 1115 waiver(s) for which the individual would be eligible: \_\_\_\_\_

**2. Medically Needy. (Select one):**

<input checked="" type="radio"/>	The State does not provide State plan HCBS to the medically needy.
<input type="radio"/>	The State provides State plan HCBS to the medically needy ( <i>select one</i> ):
<input type="radio"/>	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a State makes this election, medically needy individuals only receive 1915(i) services.
<input type="radio"/>	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

## Evaluation/Reevaluation of Eligibility

**1. Responsibility for Performing Evaluations/Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

<input checked="" type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By Other ( <i>specify State agency or entity under contract with the State Medicaid agency</i> ):

**2. Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. (Specify qualifications):

For all target groups, the minimum qualifications for independent individuals performing initial evaluations for eligibility are as follows:

- State classification of Senior Social Worker/Case Manager or equivalent standards for education and experience, with additional disability-specific training provided as needed to effectively perform evaluation.

For all target groups, reevaluations are conducted by individuals holding an associate's degree or higher in a behavioral, social sciences, or a related field OR experience in health or human services support which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

**3. Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make

this determination. If the reevaluation process differs from the evaluation process, describe the differences:

To facilitate access to the benefit, Delaware will be utilizing the Aging and Disability Resource Center (ADRC) as an initial no wrong door entry point for individuals new to the delivery system. Individuals already enrolled or identified as eligible for Pathways through an operating division do not need to go through the ADRC before the process initiates. The ADRC will do a preliminary screening to determine interest in work and likely target group eligibility. This screen will collect information on employment interest, available service history information, and a preliminary review of target group. The ADRC will perform a referral, conveying all applicable information to the entity conducting evaluation. Referrals will occur on an ongoing basis, as individuals contact the ADRC. Protocols for referrals will be developed and overseen by the administering divisions and DMMA, with the aim being a seamless experience for individuals accessing the Pathways program.

The Assessment Manager will ensure the completion of the formal initial evaluation of whether the individual meets the targeting and needs-based criteria. This evaluation will include a thorough review of documentation such as the individual's medical history, visual acuity documented in accordance with state requirements, functional support needs related to activities of daily living (ADL), and cognitive and adaptive functioning, as applicable to the needs-based criteria for the appropriate target group.

For individuals with an active institutional level of care determination (either for NF or ICF/IID), which is more stringent than the needs-based criteria for all target groups, a determination will be made that they meet the needs-based criteria, so long as they have also expressed desire to work and meet applicable targeting criteria.

The single state Medicaid agency will make final determinations regarding program eligibility.

Reevaluations will be conducted by a qualified professional as described in Item #2 above and will include a review to verify that individuals continue to meet the applicable needs-based criteria.

4. ☒ **Reevaluation Schedule.** *(By checking this box, the State assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.
5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box, the State assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS. The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Individuals who have a desire to work in a competitive work environment and for which the services provided herein are not otherwise available to the individual under either special education and related services as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16) and (17)) or vocational rehabilitation services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Group A	Group B	Group C
Individuals who are Visually Impaired	Individuals with Physical Disabilities	Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's

		Syndrome
Individuals are unemployed or underemployed or are at risk of losing their job without supports.	Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least 1 ADL and who are at risk of being unable to sustain competitive employment without supports.	Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box, the State assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the State has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

#### Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	Nursing Facility (NF) (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)
<p>Group A</p> <p>Individuals who are Visually Impaired</p> <p>Individuals are unemployed or underemployed or are at risk of losing their job without supports.</p>	The individual must have deficits in at least 2 ADLs.	Individual:
<p>Group B</p> <p>Individuals with Physical Disabilities</p> <p>Individuals whose physical condition affects their ability to live independently, who need ongoing assistance with at least 1 ADL and who are at risk of being unable to sustain competitive employment without supports.</p>		<p>1) Has a diagnosis of intellectual or developmental disability and has been deemed eligible for services through the Division of Developmental Disabilities Services (DDDS).</p> <p>2) Has been recommended for an ICF/MR level of care based on a medical evaluation (MAP 25) completed by a doctor of medicine or osteopathy, and includes the relevant medical information necessary to evaluate an individual's need for an ICF/MR level of care.</p>
<p>Group C</p>		<p>The diagnosis of Intellectual or Developmental Disability is determined based on:</p> <p>1) The administration of the</p>



<p>Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome.</p> <p>Individuals with significant limitations in adaptive function and/or who need assistance with at least one area of ADL, and/or who have difficulty understanding and interpreting social situations and who are unlikely to be able to obtain or sustain competitive employment without supports.</p>		<p>Adaptive Behavior Assessment System (ABAS) or Vineland Adaptive Behavior Scale (VABS) by a licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry who certifies that the individual/applicant has significantly sub-average intellectual functioning or otherwise meets the following criteria:</p> <p>b. An adaptive behavior composite standard score of 2 or more standard deviations below the mean; or a standard score of two or more standard deviations below the mean in one or more component functioning areas (ABAS: Conceptual, Social; Practical: VABS: Communication; Daily living Skills, Social).</p>
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\*Long Term Care/Chronic Care Hospital

7. ☒ **Target Group(s).** The State elects to target this 1915(i) State plan HCBS benefit to a specific population. With this election, the State will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the State may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C). (*Specify target group(s)*):

Delaware defines the following target groups:

Group A	Group B	Group C
Individuals who are Visually Impaired	Individuals with Physical Disabilities	Individuals with Intellectual Disabilities, Autism Spectrum Disorders or Asperger's Syndrome
Individuals age 14 to 25 determined by a doctor of optometry or ophthalmology to be: totally blind (no light perception), legally blind (20/200 in the better eye with correction, or a field restriction of 20 degrees or less) or severely visually impaired (20/70 to 20/200 in the better eye with correction).	Individuals age 14 to 25 with a physical disability; whose physical condition is anticipated to last 12 months or more.	Individuals age 14 to 25 with intellectual developmental disorder attributed to one or more of the following: IQ scores of 2 standard deviations below the mean, autism spectrum disorder, Asperger's disorder, Prader-Willi Syndrome, as defined in the APA Diagnostic and Statistical Manual, brain injury or neurological condition related to IDD that originates before age 22.

(By checking the following boxes, the State assures that):

8. ☒ **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).
9. ☒ **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:
- (i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or
  - (ii) Resides in a home or apartment that is owned, leased, or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State and approved by CMS. (If applicable, specify any residential settings, other than an individual's home or apartment, in which 1915(i) participants will reside. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):

## Person-Centered Planning & Service Delivery

(By checking the following boxes, the State assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:
- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified;
  - Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not

limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;

- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the POC;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the POC, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. **X** Based on the independent assessment, the individualized POC:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control ;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

3. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS. (*Specify qualifications*):

Face-to-Face Assessments are conducted by individuals holding a minimum of an associate's degree or higher in a behavioral, social sciences or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

4. **Responsibility for POC Development.** There are qualifications (that are reasonably related to developing POC) for persons responsible for the development of the individualized, person-centered POC. (*Specify qualifications*):

POC development will be conducted by individuals holding a minimum of an associate's degree or higher in a behavioral, social sciences or a related field OR having experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social or financial needs in accordance with program requirements.

5. **Supporting the Participant in POC Development.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the

POC development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Individuals will be actively supported in the development of their person-centered POC. The process will:

1. Include people chosen by the individual.
2. Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
3. Be timely and be scheduled at times and locations of convenience to the individual.
4. Reflect cultural considerations of the individual.
5. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
6. Offer the full array of choices to the individual regarding the services and supports they receive and from whom.
7. Include a method for the individual to request updates to the plan.

**6. Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the POC):*

Through the person-centered planning process, as well as through available online resources providing provider information sorted geographically, individuals are informed about all willing and qualified providers available from which to choose.

Prior to the development of a care plan, participants and/or their legal guardians or representatives are provided with information about the freedom to choose among providers. Participants are also given a list of providers and can choose among these service providers. The information is provided to participants at least annually. In addition, provider lists will be available to participants at any time during their enrollment in the Pathways program.

Information will be provided to individuals in an accessible manner, taking into consideration individual's unique communication needs, including consideration for language and needed accessibility accommodations.

**7. Process for Making POC Subject to the Approval of the Medicaid Agency.** *(Describe the process by which the POC is made subject to the approval of the Medicaid agency):*

All POC are subject to review by an approving entity within the Single State Medicaid agency. In addition, in the performance of oversight functions, a representative sample of all POC will be reviewed to ensure compliance with all requirements.

**8. Maintenance of POC Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

<input checked="" type="checkbox"/>	Medicaid agency	<input type="checkbox"/>	Operating agency	<input type="checkbox"/>	Case manager
<input type="checkbox"/>	Other (specify):				

**1. State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

<b>Service Specifications</b> <i>(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):</i>	
Service Title:	Employment Navigator (Case Management)
Service Definition (Scope):	
<p>Employment Navigators assist participants in gaining access to needed employment and related supports. This service ensures coordination between employment and related supports and other State plan services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.</p> <p>Employment Navigators are responsible for collecting information for evaluating and/or re-evaluating the individual's needs-based eligibility and for performing assessments to inform the development of the person-centered employment plan.</p> <p>In the performance of providing information to individuals served through Pathways, the Employment Navigator:</p> <ul style="list-style-type: none"> <li>• Informs individuals about the Pathways HCBS services, required needs assessments, the person-centered planning process, service alternatives, service delivery options (opportunities for participant-direction), roles, rights, risks, and responsibilities.</li> <li>• Informs individuals on fair hearing rights and assist with fair hearing requests when needed and upon request.</li> </ul> <p>In the performance of facilitating access to needed services and supports, the Employment Navigator:</p> <ul style="list-style-type: none"> <li>• Collects additional necessary information including, at a minimum, preferences, strengths, and goals to inform the development of the individual's service plan.</li> <li>• Assists the individual and his/her service planning team in identifying and choosing willing and qualified providers.</li> <li>• Coordinates efforts and prompts the individual to ensure the completion of activities necessary to maintain Pathways program eligibility.</li> </ul> <p>In the performance of the coordinating function, the Employment Navigator:</p> <ul style="list-style-type: none"> <li>• Coordinates efforts and prompt the individual to participate in the completion of a needs assessment to identify appropriate levels of need and to serve as the foundation for the development of and updates to the Employment service plan.</li> <li>• Uses a person-centered planning approach and a team process to develop the individual's Employment Plan to meet the individual's needs in the least restrictive manner possible.</li> <li>• Develops and updates the Employment service plan based upon the needs assessment and person-centered planning process annually, or more frequently as needed.</li> <li>• Explores coverage of services to address individuals' identified needs through other sources, including services provided under the State Plan, Medicare, and/or private insurance or other community resources.</li> </ul>	

- Coordinates, as needed, with other individuals and/or entities essential in the delivery of services for the individual, including MCO care coordinators, as well vocational rehabilitation and education coordinators to ensure seamless coordination among needed support services and to ensure that the individual is receiving services as appropriate from such other sources.
- Coordinates with providers and potential providers of services to ensure seamless service access and delivery.
- Coordinates with the individual's family, friends, and other community members to cultivate the individual's natural support network.

In the performance of the monitoring function, the Employment Navigator:

- Monitors the health, welfare, and safety of the individual and the Employment Plan implementation through regular contacts at a minimum frequency as required by the department.
- Responds to and assesses emergency situations and incidents and ensure that appropriate actions are taken to protect the health, welfare, and safety of the individual.
- Reviews provider documentation of service provision and monitor individual progress on employment outcomes and initiate meetings when services are not achieving desired outcomes.
- Through the service plan monitoring process, solicits input from the individual and/or family, as appropriate, related to satisfaction with services.

Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or other sources.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

X	Categorically needy ( <i>specify limits</i> ): Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: <ul style="list-style-type: none"> <li>• incentive payments made to an employer to encourage or subsidize the employer's participation in Job Finding services, and</li> <li>• payments that are passed through to users of the Employment Navigator services</li> </ul>
□	Medically needy ( <i>specify limits</i> ): 

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
<b>Employment Navigator Provider</b>	State Government or State Business License or 501		Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.

<b><i>The providers of this service will be limited per concurrent operation with 1115 demonstration granting waiver of free choice of providers for this service, necessary to ensure conflict free status, access, and quality.</i></b>	(c)(3) status (if applicable)		Individuals providing this service must: <ul style="list-style-type: none"> <li>• Have an associate's degree or higher in a behavioral, social sciences, or a related field OR experience in health or human services support, which includes interviewing individuals and assessing personal, health, employment, social, or financial needs in accordance with program requirements.</li> <li>• Complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.</li> <li>• Comport with other requirements as determined by the Department.</li> </ul>
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
Employment Navigator	Department or Designee		Initially and annually or more based on service monitoring concerns.
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

<b>Service Specifications</b> (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):	
Service Title:	Career Exploration and Assessment
Service Definition (Scope):	
Career Exploration and Assessment is a person-centered, comprehensive employment planning and support service that provides assistance for program participants to obtain, maintain, or advance in competitive employment or self-employment. It is a focused, time limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the State's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan, including any necessary education and training, used to guide individual employment support.	

This service may include conducting community based career assessment. The assessment may include:

- conducting a review of the participant's work history, interests and skills;
- identifying types of jobs in the community that match the participant's interests, abilities, and skills;
- identifying situational assessments (including job shadowing or job tryouts) to assess the participant's interest and aptitude in a particular type of job; and/or
- developing a report that specifies recommendations regarding the participant's individual needs, preferences, abilities, and characteristics of an optimal work environment. The report must also specify if education, training, or skill development is necessary to achieve the participant's employment or career goals, with an indication of whether those elements may be addressed by other related services in the participant's service plan or other sources.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs requiring translation.

The service also includes transportation as an integral component of the service, such as to a job shadowing opportunity, during the delivery of Career Exploration and Assessment.

Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age.

Documentation is maintained that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

- ☒ Categorically needy (*specify limits*):
- Career Exploration and Assessment may be authorized for up to 6 months in a benefit year, with multi-year service utilization and reauthorization only with explicit written Department approval.
- Federal Financial Participation (FFP) is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
- incentive payments made to an employer to encourage or subsidize the employer's participation in Job Finding services and
  - payments that are passed through to users of the Career Exploration services

☐ Medically needy (*specify limits*):

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
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<b>Career Exploration Agency</b>	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS HCBS Waiver Criteria)	<p>Comply with all Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.</p> <p>Meet minimum standards as set forth by the Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.</p> <p>Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.</p> <p>Individuals employed by providers must:</p> <ul style="list-style-type: none"> <li>• Have criminal background investigations in accordance with state requirements.</li> <li>• Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</li> <li>• Be state licensed (as applicable), or registered in their profession as required by state law.</li> <li>• In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.</li> </ul>
<b>Verification of Provider Qualifications</b> <i>(For each provider type listed above. Copy rows as needed):</i>			
Provider Type <i>(Specify):</i>	Entity Responsible for Verification <i>(Specify):</i>		Frequency of Verification <i>(Specify):</i>
Career	Department or Designee		Initially and annually or

Exploration Agency		more based on service monitoring concerns.
<b>Service Delivery Method.</b> ( <i>Check each that applies</i> ):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> X	Provider managed

<b>Service Specifications</b> ( <i>Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover</i> ):	
Service Title:	Supported Employment - Individual
Service Definition (Scope):	
<p>Individual Supported Employment services are the ongoing supports provided, at a one-to-one participant to staff ratio, to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce. Jobs in competitive and customized employment must provide compensation at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.</p> <p>Individual Supported Employment may also include support to establish or maintain self-employment, including home-based self-employment with business generated income for the individual. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.</p> <p>Competitive and integrated employment, including self-employment, shall be considered the first option when serving persons with disabilities who are of working age to obtain employment.</p> <p>Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency, or who have other communication needs requiring translation.</p> <p>Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).</p>	
Additional needs-based criteria for receiving the service, if applicable ( <i>specify</i> ):	
Specify limits (if any) on the amount, duration, or scope of this service for ( <i>choose each that applies</i> ):	
<input checked="" type="checkbox"/> X	Categorically needy ( <i>specify limits</i> ):
	Individual Supported Employment does not include facility-based or other similar types of

	<p>vocational services furnished in specialized facilities that are not a part of the general workplace.</p> <p>Individual Supported Employment services do not include volunteer work and may not be used for job placements paying below minimum wage.</p> <p>Job placement support provided as a component of this service is time-limited, requiring re-authorization every 90 days, up to 6 months in a benefit year months. At each 90-day interval, the service plan team will meet to clarify goals and expectations and review the job placement strategy.</p> <p>The Individual Supported Employment Services service provider must maintain documentation in accordance with Department requirements.</p> <p>Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.</p> <p>FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <ul style="list-style-type: none"> <li>• Incentive payments made to an employer to encourage or subsidize the employer's participation in Individual Employment Support Services</li> <li>• Payments that are passed through to users of Individual Employment Support Services</li> </ul> <p>Individual Supported Employment Services does not include payment for supervision, training, support, and adaptations typically available to workers without disabilities.</p>		
<input type="checkbox"/>	Medically needy ( <i>specify limits</i> ):		
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Supported Employment Agency	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Waiver Criteria); and, DVR Vendor for Job Development, Placement and Retention Services	<p>Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.</p> <p>Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.</p> <p>Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to,</p>

			<p>communication, mobility, and behavioral needs.</p> <p>Individuals employed by providers must:</p> <ul style="list-style-type: none"> <li>• Have criminal background investigations in accordance with state requirements.</li> <li>• Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</li> <li>• Be state licensed (as applicable), or registered in their profession as required by state law.</li> <li>• In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.</li> </ul>
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**Verification of Provider Qualifications** (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Supported Employment Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

**Service Delivery Method.** (Check each that applies):

<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
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**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title:	Supported Employment - Small Group
Service Definition (Scope):	
<p>Small Group Supported Employment are services and training activities provided in regular business, industry and community settings for groups of two (2) to no more than four (4) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small Group Supported Employment must be provided in a manner that promotes integration into the workplace and</p>	

interaction between participants and people without disabilities in those workplaces and be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small Group Supported Employment does not include vocational services provided in facility based work settings, enclaves or other non-competitive or non-integrated job placements.

Small Group Supported Employment may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support, training and planning transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the participant to be successful in integrating into the job setting.

Small Group Supported Employment emphasizes the importance of rapid job search for a competitive job and provide work experiences where the consumer can develop strengths and skills that contribute to employability in individualized paid employment in integrated community settings

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

X

Categorically needy (*specify limits*):

Continuation of Small Group Supported Employment requires a review and reauthorization every 6 months in accordance with Department requirements, and shall not exceed 12 continuous months without exploration of alternative services. The review and reauthorization should verify that there have been appropriate attempts to prepare the consumer for a transition to Individualized Employment Support Services (IESS) and that the consumer continues to prefer Small Group Supported Employment, despite these attempts.

Job placement support provided as a component of this service is time-limited, requiring re-authorization every 90 days, up to 6 months in a benefit year months. At each 90-day interval, the service plan team will meet to clarify goals and expectations and review the job placement strategy.

Small Group Supported Employment does not include facility-based or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace.

<p>Small Group Supported Employment services do not include volunteer work and may not be for job placements paying below minimum wage.</p> <p>The Small Group Supported Employment Services service provider must maintain documentation in accordance with Department requirements.</p> <p>Except as permitted in accordance with requirements contained in Department guidance, policy and regulations, this service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.</p> <p>FFP is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <ul style="list-style-type: none"> <li>• incentive payments made to an employer to encourage or subsidize the employer's participation in Small Group Supported Employment Services and</li> <li>• payments that are passed through to users of Small Group Employment Support Services</li> </ul> <p>Small Group Employment Support Services does not include payment for supervision, training, support, and adaptations typically available to workers without disabilities.</p> <p>Small Group Supported Employment Supports is not a pre-requisite for Individual Supported Employment.</p>			
<input type="checkbox"/> Medically needy ( <i>specify limits</i> ):			
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
<b>Provider Type</b> ( <i>Specify</i> ):	<b>License</b> ( <i>Specify</i> ):	<b>Certification</b> ( <i>Specify</i> ):	<b>Other Standard</b> ( <i>Specify</i> ):
<b>Supported Employment agency</b>	State Business License or 501 (c)(3) status	Pathways Certified Provider (utilizing DDDS Waiver Criteria); and, DVR Vendor for Job Development, Placement and Retention Services	<p>Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.</p> <p>Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.</p> <p>Ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral</p>

			<p>needs.</p> <p>Individuals employed by providers must:</p> <ul style="list-style-type: none"> <li>• Have criminal background investigations in accordance with state requirements.</li> <li>• Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</li> <li>• Be state licensed (as applicable), or registered in their profession as required by state law.</li> <li>• In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.</li> </ul>

**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed):*

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Supported Employment Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

**Service Delivery Method.** *(Check each that applies):*

<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
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**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

Service Title:	Benefits Counseling
Service Definition (Scope):	
<p>Benefits Counseling provides work incentive counseling services to Pathways to Employment participants seeking to work while maintaining access to necessary healthcare and other benefits. Benefits counseling will provide information to individuals regarding available benefits and assist individuals to understand options for making an informed choice about going to work while maintaining essential benefits.</p>	

This service will assist individuals to understand the work incentives and support programs available and the impact of work activity on those benefits. This service will assist individuals to understand their benefits supports and how to utilize work incentives and other tools to assist them to achieve self-sufficiency through work.

This service will also include the development and maintenance of proper documentation of services, including creating Benefits Summaries and Analyses and Work Incentive Plans.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation/interpretation services for participants that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding and use of communication devices used by the participant.

This service is in addition to information provided by the Aging and Disability Resource Centers (ADRC), SHIP or other entities providing information regarding long-term services and supports.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Individuals may not have access to this service from any other source.

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

☒ Categorically needy (*specify limits*):

20 hours per year maximum with exceptions possible with explicit written Departmental approval.

☐ Medically needy (*specify limits*):

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Benefits Counseling Agency	State Business License or 501 (c)(3) status	Community Partner Work Incentives Counseling (CPWIC) Certification issued by an appropriate accrediting body as authorized by the Social Security Administration (SSA).	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.  Ensure employees and/or contractors complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.



			<p>Individuals employed or contracted by providers must:</p> <ul style="list-style-type: none"> <li>• Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</li> <li>• Be state licensed (as applicable), or registered in their profession as required by state law.</li> <li>• In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.</li> </ul>
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**Verification of Provider Qualifications** (For each provider type listed above. Copy rows as needed):

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Benefits Counseling Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)

**Service Delivery Method.** (Check each that applies):

<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed
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**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title:	Financial Coaching Plus
Service Definition (Scope):	
<p>Financial Coaching Plus uses a financial coaching model to assist individuals in establishing financial goals, creating a plan to achieve them, and providing information, support, and resources needed to implement stated goals in the financial plan. The financial coach will assist the client seeking to improve his/her financial situation in order to improve economic self-sufficiency. Financial Coaching Plus includes the development of a personal budget and identifies reliable and trusted savings, credit, and debt programs that promote financial stability. The content and direction of the coaching is customized to respond to the individual financial goals set by the participant. Financial coaching is provided to the client one-on-one in a setting convenient for the client over a time-limited series of sessions and follow-up to increase the opportunity for self-directed behavior skills learning.</p>	

The Financial Coach will:

- Assist the client in developing financial strategies to reach participant's goals with care to ensure that personal strategies reflect considerations related to benefits, as identified through benefits counseling;
- Ensure that individuals understand the availability of various tax credits such as the Earned Income Tax Credit, Child Care Tax Credit, and others;
- Refer individuals as needed to benefit counselors;
- Provide information to complement information provided through benefits counseling regarding appropriate asset building;
- Use an integrated dashboard of available community-based asset building opportunities and financial tools/services to ensure participants are leveraging all resources to increase economic self-sufficiency;
- Provide information about how to protect personal identify and avoid predatory lending schemes;
- Provide assistance with filing yearly taxes either through the IRS VITA program or its virtual program that involves self-filing.

The Financial Coaching Plus service will include the collection and maintenance of proper documentation of services provided as required by the Department that will track goals, actions, and outcomes of individual participants.

The Financial Coaching Plus service may complement information provided on the use of public benefits and/or work incentives through Benefits Counseling or other services.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) or other services.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*chose each that applies*):

☒ Categorically needy (*specify limits*):

Financial Coaching Plus service limited to five hours per participant per year.

☐ Medically needy (*specify limits*):

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Financial Coaching Agency	State Business License or 501 (c)(3) status	An agency must demonstrate that Financial Coaches who will provide this service are certified in the	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.  The provider, including its parent

		<p>financial coaching curriculum developed by the Department of Health and Social Services and the University of Delaware Alfred Lerner College of Business and Economics and the Division of Professional Continuing Studies.</p>	<p>company and its subsidiaries, and any sub provider, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del Code Chapter 58, Laws Regulating the Conduct of Officers and Employees of the State and in particular with Section 5805 (d) Post Employment Restrictions.</p> <p>Ensure employees and/or contractors complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.</p> <p>Individuals employed or contracted by providers must:</p> <ul style="list-style-type: none"> <li>• Have criminal background investigations in accordance with state requirements.</li> <li>• Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</li> <li>• Be state licensed (as applicable), or registered in their profession as required by state law.</li> <li>• In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.</li> </ul> <p>An agency must demonstrate that Financial Coaches who will provide this service:</p> <ul style="list-style-type: none"> <li>• Have at least one year of full time financial coaching experience.</li> <li>• Are trained in Financial Coaching Plus strategies specific to the</li> </ul>
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			Pathways population.
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):	
Financial Coaching Plus Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)	
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title: Non-Medical Transportation

**Service Definition (Scope):**

Service offered in order to enable participants to gain access to employment services, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the Pathways program are offered in accordance with the participant's service plan. Whenever possible and as determined through the person-centered planning process, family, neighbors, friends, carpools, coworkers, or community agencies which can provide this service without charge must be utilized.

Non-medical Transportation services are offered, in addition to any medical transportation furnished under the 42 CFR 440.17(a) in the State Plan. Non-medical Transportation services are necessary, as specified by the service plan to enable individuals to gain access to employment services. In order to be approved, non-medical transportation would need to be directly related to a goal on the individual's treatment plan (e.g., to a supported employment) and not for the general transportation needs of the client (e.g., regular trips to the grocery store). This service will be provided to meet the individual's needs as determined by an assessment performed in accordance with Department requirements and as specifically outlined in the individual's POC.

Transportation services will be delivered through a transportation broker who will arrange and/or provide services pursuant to the plan of care.

Such transportation may also include public transportation - The utilization of Public Transportation promotes self-determination and is made available to individuals as a cost-effective means of accessing services and activities. This service provides payment for the individual's use of public transportation to access employment.

The Employment Supports Coordinator will monitor this service quarterly and will provide ongoing assistance to the individual to identify alternative community-based sources of transportation.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or any other source.			
Additional needs-based criteria for receiving the service, if applicable ( <i>specify</i> ):			
Specify limits (if any) on the amount, duration, or scope of this service for ( <i>chose each that applies</i> ):			
X	Categorically needy ( <i>specify limits</i> ):		
	The service does not provide for mileage reimbursement for a person to drive himself to work. Individuals may not receive this service at the same time as Supported Employment (individual or group) if those services are providing transportation to and from the employment setting.		
<input type="checkbox"/>	Medically needy ( <i>specify limits</i> ):		
<b>Provider Qualifications</b> ( <i>For each type of provider. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Transportation Broker Agency  <i>The providers of this service will be limited per concurrent operation with 1115 demonstration granting waiver of free choice of providers for this service, necessary to ensure conflict free status, access and quality.</i>	State Business License or 501 (c)(3) status	Broker	All drivers possess a valid driver's license. All vehicles are properly registered and insured.
<b>Verification of Provider Qualifications</b> ( <i>For each provider type listed above. Copy rows as needed</i> ):			
Provider Type ( <i>Specify</i> ):	Entity Responsible for Verification ( <i>Specify</i> ):		Frequency of Verification ( <i>Specify</i> ):
Transportation Agency	Department or Designee		Initially and annually (or more frequent based on service monitoring concerns)
<b>Service Delivery Method.</b> ( <i>Check each that applies</i> ):			
<input type="checkbox"/>	Participant-directed		<input checked="" type="checkbox"/> Provider managed

**Service Specifications** (*Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover*):

Service Title: Personal Care

Service Definition (Scope):

Personal care includes assistance with ADLs (bathing, dressing, personal hygiene, transferring, toileting, skin care, eating and assisting with mobility), as needed to assist an individual in the workplace. When specified in the POC, this service may include assistance with instrumental activities of daily living (IADL) (e.g. task completion). Assistance with IADL's must be essential to the health and welfare of the participant. Personal care may also provide stand-by assistance in the workplace to individuals who may require support on an intermittent basis due to a disability or medical condition.

This service is intended to provide personal care for individuals in getting ready for work, in getting to work or at the workplace.

This service does not duplicate a service provided under the State plan as an expanded EPSDT service or services available to the individual through other Medicaid programs, including the DSHP Plus and any waiver operated by DDDS.

Personal Care may include escorting individuals to the workplace, but does not include the cost of transportation.

Services must be delivered in a manner that supports the participant's communication needs including, but not limited to, age appropriate communication, translation services for participants that are of limited-English proficiency or who have other communication needs.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

☒ Categorically needy (*specify limits*):

This service is over and above that which is available to the individual through the State Plan EPSDT benefit, the DSHP Plus program, or the DDDS waiver, as applicable.

☐ Medically needy (*specify limits*):

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
Home Health Agency	State Business License or 501 (c)(3) status; and State Home Health Agency License from Office of Health	N/A	Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.  Complete and ensure employees complete Department-required training,

	Facilities Licensing and Certification per Delaware Code Title 16-4406 Home Health Agencies (Licensure).		<p>including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.</p> <p>Individuals employed by providers must:</p> <ul style="list-style-type: none"> <li>• Be at least 18 years of age.</li> <li>• Have criminal background investigations in accordance with state requirements.</li> <li>• Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</li> </ul> <p>In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.</p>
Personal Assistance Services Agency	State Business License or 501(c)(3) status; and State Personal Assistance Services Agency License from Office of Health Facilities Licensing and Certification per Delaware Code Title 16-4469.	N/A	<p>Comply with Department standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications.</p> <p>Complete and ensure employees complete Department-required training, including training on the participant's service plan and the participant's unique and/or disability-specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.</p> <p>Individuals employed by providers must:</p> <ul style="list-style-type: none"> <li>• Be at least 18 years of age.</li> <li>• Have criminal background investigations in accordance with state requirements.</li> <li>• Have a screening against the child abuse and adult abuse registry checks and obtain service letters in</li> </ul>

			<p>accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</p> <ul style="list-style-type: none"> <li>In the case of direct care personnel, possess certification through successful completion of training program as required by the Department.</li> </ul>
Personal Attendant	N/A	N/A	<ul style="list-style-type: none"> <li>Must have the ability to carry out the tasks required by the participant.</li> <li>Must have the ability to communicate effectively with the participant.</li> <li>Have criminal background investigations in accordance with state requirements.</li> <li>Have a screening against the child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del Code Section 708 and 11 Del Code Sections 8563 and 8564 and not have an adverse registry findings in the performance of the service.</li> <li>Must be at least 18 years of age. (Exceptions to the age requirement are made on a case-by-case basis and require written authorization by the participant case manager.)</li> <li>Must complete training through Support for Participant Direction vendor within 90 days of enrollment as a provider. (Exceptions to the training requirement are made by the Support for Participant Direction vendor on a case-by-case basis for emergency back-up providers.)</li> </ul>

**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed):*

Provider Type (Specify):	Entity Responsible for Verification (Specify):	Frequency of Verification (Specify):
Home Health Agency	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)
Personal	Department or Designee	Initially and annually (or



Assistance Services Agency		more frequent based on service monitoring concerns)
Personal Attendant	Department or Designee	Initially and annually (or more frequent based on service monitoring concerns)
<b>Service Delivery Method.</b> (Check each that applies):		
<input checked="" type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):

Service Title: Orientation, Mobility, and Assistive Technology

**Service Definition (Scope):**

Assistive technology device means an item, piece of equipment or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device to increase independence in the workplace. Independent evaluations conducted by a certified professional, not otherwise covered under the State Plan services, may be reimbursed as a part of this service. Evaluations to determine need for assistive technology and to identify the appropriate technology to support individuals in employment settings are required. Assistive technology includes:

- (A) the evaluation and assessment of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
- (B) the cost of the item, including purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
- (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- (D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the service plan;
- (E) training, demonstrations and/or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
- (F) training, demonstrations and/or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive technology may include augmentative communication devices, adapted watches, high and low teach adaptive/assistive equipment such as video magnifiers, Braille displays, hardware and software.

**Orientation and Mobility**

Orientation and Mobility provides consumers training to develop the necessary skills to travel

independently and safely. This is accomplished one on one with the usage of white canes, guide dogs, or other equipment. Orientation and Mobility instruction is a sequential process where visually impaired individuals are taught to utilize their remaining senses to determine their position within their environment and to negotiate safe movement from one place to another. This service does not duplicate a service provided under the State plan as an expanded EPSDT service.

Items designed for general use shall only be covered to the extent necessary to meet the participant's assessed needs and are primarily used by a participant to address a therapeutic purpose.

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or any other source.

Additional needs-based criteria for receiving the service, if applicable (*specify*):

These assessments, items or services must not otherwise be available to individuals under the DSHP or DSHP Plus Program.

Assistive Technology devices must be obtained at the lowest cost.

The amount of this service for Assistive Technology devices is limited to \$10,000 for the participant's lifetime. This amount includes replacement parts and repair when it is more cost effective than purchasing a new device. Exceptions to this limit may be considered based upon a needs assessment and prior authorization by the Department.

Specify limits (if any) on the amount, duration, or scope of this service for (*choose each that applies*):

☒ Categorically needy (*specify limits*):

☐ Medically needy (*specify limits*):

**Provider Qualifications** (*For each type of provider. Copy rows as needed*):

Provider Type ( <i>Specify</i> ):	License ( <i>Specify</i> ):	Certification ( <i>Specify</i> ):	Other Standard ( <i>Specify</i> ):
<b>Certified Orientation and Mobility Specialist</b>	n/a	COMS	Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
<b>Certified Vision Rehabilitation Therapist</b>	n/a	CVRT	Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
<b>Occupational Therapist</b>	OTR/L	AOTA SCEM	Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
<b>Assistive Technology Professional</b>	n/a	ATP RESNA Rehabilitation Engineering and Assistive Technology Society of North	Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.

		America	
<b>Low Vision Therapist</b>	n/a	LVT - Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP)	Meet minimum standards as set forth by Division of Vocational Rehabilitation or Division for the Visually Impaired as applicable for comparable services.
<b>Durable Medical Equipment Suppliers</b>	State Business License or 501 (c)(3) status		
<b>Assistive Technology Suppliers</b>	State Business License or 501 (c)(3) status		
<b>Verification of Provider Qualifications</b> (For each provider type listed above. Copy rows as needed):			
Provider Type (Specify):	Entity Responsible for Verification (Specify):		Frequency of Verification (Specify):
All Provider Types	Department or Designee		Initially and annually (or more frequent based on service monitoring concerns)
<b>Service Delivery Method.</b> (Check each that applies):			
<input type="checkbox"/>	Participant-directed	<input checked="" type="checkbox"/>	Provider managed

3. **X Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** (By checking this box, the State assures that): There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. (Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the State ensures that the provision of services by such persons is in the best interest of the individual; (d) the State's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):

(a) Spouses of participants may be paid to provide personal care services under the circumstances described below.

(b) Payment is authorized for spouses to provide only those personal care services designated in the care plan which respond to a specific deficit or deficits in a participant's capacity to carry out ADLs and/or IADLs and which represent extraordinary care not typically provided by spouses in the absence of these deficits. The service plan includes authorization for service hours that include only those services and supports not ordinarily provided by a spouse in the absence of ADL and/or IADL deficits, including such supports as health maintenance activities; bathing and personal hygiene;

bowel or urinary evacuation; and feeding. Activities which might, in the absence of ADL and/or IADL deficits, be considered shared responsibilities of spouses or members of a household, such as shopping, cleaning, or bill payment, are not considered for reimbursement for spousal personal care attendants under the Pathways program, except under unusual circumstances and at the discretion of the Employment Navigator.

(c) Under this program, participants who choose to self-direct some or all of their personal care services have employer authority. A specified number of personal care hours are authorized in a participant's care plan based on his/her individual needs. The participant, as employer of a personal care provider, including a spousal provider, is responsible for making sure that the personal care service is delivered by his/her attendant in such a way as to address the specific ADL and/or IADLs noted in the care plan. Regular contact between the participant and the Employment Navigator, and the Support for Participant Direction provider ensure that the participant's service needs are being met, including those service needs being met by the spousal personal care attendant. Face-to-face visits between the Support for Participant Direction Provider and the participant are held at a minimum twice per year when the participant chooses to employ a spouse to provide some or all of his or her authorized personal care services.

## Participant-Direction of Services

*Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).*

### 1. Election of Participant-Direction. (Select one):

<input type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input checked="" type="radio"/>	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the State. (Specify criteria):

### 2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

Personal care is the only service offered under the 1915(i) for which there are self-direction opportunities. All participants in Pathways who receive personal care services are offered the opportunity for employer authority to self-direct these personal care services. Individuals are informed of the opportunity for self-direction during the person-centered planning process. Individuals (or parents in the case of minor children) may elect to serve as the employer of record for these services. Individuals receive information and assistance in support of participant direction and vendor/fiscal employer agent support from an entity(ies) contracted with the state for the provision of these services.

### 3. Limited Implementation of Participant-Direction. (Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):

X	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect self-directed service delivery options offered by the State, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. <i>(Specify the areas of the State affected by this option):</i>

**4. Participant-Directed Services.** *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
Personal Care	X	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

**5. Financial Management.** *(Select one):*

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
X	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

**6. X Participant-Directed POC.** *(By checking this box, the State assures that):* Based on the independent assessment, a person-centered process produces an individualized POC for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans, that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

**7. Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

**Voluntary Termination of Participant Direction**

An individual who elects to receive participant-directed personal care services can elect to terminate participant direction at any time. The state ensures the continuity of services for and the health and welfare of the participant who elects to terminate participant-directed personal care services.

A participant who elects to terminate participant direction is able to receive personal care services

through an agency which has an agreement to provide such services under the Pathways program.

### **Involuntary Termination of Participant Direction**

Participants who opt to self-direct some or all of their personal care service hours receive a great deal of support to assist them in carrying out their responsibilities. This support leads to successful participant-direction in most cases. However, there are a several circumstances under which the State would find it necessary to terminate participant direction. Specifically, the State involuntarily terminates the use of participant direction under the following circumstances:

- **Inability to self-direct.** If an individual consistently demonstrates a lack of ability to carry out the tasks needed to self-direct personal care services, including hiring, training, and supervising his or her personal care attendant, and does not have a representative available and able to carry out these activities on his/her behalf, then the State would find it necessary to terminate the use of participant direction.
- **Fraudulent use of funds.** If there is substantial evidence that a participant has falsified documents related to participant directed services (for example authorizing payment when no services were rendered or otherwise knowingly submitting inaccurate timesheets), then the State would find it necessary to terminate the use of participant direction.
- **Health and welfare risk.** If the use of participant direction results in a health and welfare risk to the participant that cannot be rectified through intervention on the part of the Support for Participant Direction provider and/or the Employment Navigator, then the State would find it necessary to terminate the use of participant direction.

In cases in which participant direction is discontinued, the Employment Navigator makes arrangements immediately with the participant to select from a list of provider-managed personal care entities (i.e., those home health agencies and personal assistance services agencies enrolled to provide services through Pathways). Once the individual has selected a new personal care provider, the Employment Navigator makes arrangements to have the agency-based service begin as soon as possible to minimize or eliminate any possible gap in service.

## **8. Opportunities for Participant-Direction**

### **a. Participant–Employer Authority** (individual can hire and supervise staff). (*Select one*):

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input checked="" type="radio"/>	Participants may elect participant-employer Authority ( <i>Check each that applies</i> ):
<input type="checkbox"/>	<b>Participant/Co-Employer.</b> The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
<input checked="" type="checkbox"/>	<b>Participant/Common Law Employer.</b> The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

### **b. Participant–Budget Authority** (individual directs a budget). (*Select one*):

<input checked="" type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.

	<p><b>Participant-Directed Budget.</b> <i>(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the POC):</i></p>
	<p><b>Expenditure Safeguards.</b> <i>(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):</i></p>

DRAFT

Quality Improvement Strategy

(Describe the State’s quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data &amp; sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation



Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	<p>1. The number and percentage of persons that report that they helped develop their service plan</p> <p>2. The number and percentage of person that report their Employment Navigator asked them what they want</p> <p>3. Number and /or percent of participants with plans of care consistent with their individual assessments.</p> <p>4. The percentage of participants whose POC contain documentation that the participant was supported to make an informed choice about their providers(s). (The number of participants</p>	<p>1. Record Review. Representative Sample; Confidence Interval = 95%</p> <p>2. Record Review. Representative Sample; Confidence Interval = 95%</p> <p>3. Record Review. Representative Sample; Confidence Interval = 95%</p> <p>4. Record review. Representative Sample; Confidence Interval = 95%</p>	DDDS, DVI, and DSAAPD (all PMs)	Continuously and Ongoing (all PMs)	<p>Each of the divisions will serve an active role in correcting identified problems, by target group. The divisions will each individually aggregate and analyze the data for their specific target group, and will utilize the Pathways workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies. Delaware will collect data to establish a benchmark against which future improvement will be measured.</p> <p>Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved</p>	Annually

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Discovery Activities					Remediation	
Requirement	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data &amp; sample size)</i>	Monitoring Responsibilities <i>(agency or entity that conducts discovery activities)</i>	Frequency	Remediation Responsibilities <i>(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</i>	Frequency of Analysis and Aggregation
	whose POC contain documentation that the participant was supposed to make an informed choice about their provider(s)/total number of participants whose plans were reviewed.)					

Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
Providers meet required qualifications.	1. The percent of providers that meet the standards for provider qualification at annual review.	1. Provider Record Review. Representative Sample; Confidence Interval = 95%	DDDS, DVI and DSAAPD (all PMs)	Continuously and Ongoing (all PMs)	<p>Each of the divisions will serve an active role in correcting identified problems. The divisions will each individually aggregate and analyze the data for their specific target group, and will utilize the Pathways workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies.</p> <p>Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.</p>	Annually

Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
The SMA retains authority and responsibility for program operations and oversight.	<p>1. Percent of needs based assessments where the decision of the reviewer was validated by the Medicaid agency</p> <p>2. Number and percent of performance reports reviewed by Medicaid Agency (Number of performance reports reviewed by Medicaid agency/total number of performance reports).</p> <p>3. Percent of DMMA's Quarterly Performance Review meetings during which PTE quality assurance and improvement are discussed Numerator: quarterly meetings during which PTE QA/I are discussed: den. all quarterly DMMA PTE meetings.</p>	<p>1. Record Review. Representative Sample; Confidence Interval = 95%</p> <p>2. Administrative Records Representative Sample; Confidence Interval = 95%</p> <p>3. Administrative records. Representative Sample; Confidence Interval = 95%</p>	DMMA	Ongoing	Each of the divisions will serve an active role in correcting identified problems, with DMMA providing oversight.	Quarterly

Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	<p>1. Number and percent of claims adhering to reimbursement methodology in the waiver application.</p> <p>2. Percentage of POC where services were delivered in accordance with service plan with regard to duration/frequency. (Number of Care Plans where services were delivered in accordance with POC in regard to duration/frequency as detailed in the service plan/Total number of Care Plans reviewed.)</p>	<p>1. Administrative Data and Record Review Representative Sample; Confidence Interval = 95%</p> <p>2. Administrative data; Record Review Representative Sample; Confidence Interval = 95%</p>	DMMA (all PMs)	Continuously and Ongoing (all PMs)	<p>Each of the divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies.</p> <p>Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.</p>	Annually

Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	<p>1. The percentage of incidents of Abuse/Neglect/Mistreatment that were reported in accordance with Department requirements.</p> <p>2. The percentage incidents of Abuse/Neglect/Mistreatment by type in which follow-up was completed in accordance with Department requirements.</p>	<p>1. Record Review. Representative Sample; Confidence Interval = 95%</p> <p>2. Record Review. Representative Sample; Confidence Interval = 95%</p>	DDDS, DVI and DSAAPD (all PMs)	Continuously and Ongoing (all PMs)	<p>Each of the divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies.</p> <p>Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.</p>	Annually

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Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
	3. The percentage of employed participants reporting that they feel safe at work. (The number of participants reporting that feel safe at work/number of participants whose services and supports were reviewed)	3. Participant Questionnaire. Representative Sample; Confidence Interval = 95%	DDDS, DVI and DSAAPD (all PMs)	Continuously and Ongoing (all PMs)	<p>Each of the divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies.</p> <p>Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.</p>	Annually

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Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
	4. The percentage of reported incidents of emergency restrictive behavior intervention strategies implemented according to DDDS Behavioral and/or Mental Health Support Policy.	4. Representative Sample; Confidence Interval = 95%.	DDDS, DVI and DSAAPD (all PMs)	Continuously and Ongoing (all PMs)	<p>Each of the divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies.</p> <p>Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.</p>	Annually



Discovery Activities					Remediation	
Requirement	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity that conducts discovery activities)	Frequency	Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Frequency of Analysis and Aggregation
Employment Related Measures	Percent of Persons who: (a) have a paid job in the community (b) do not have a paid job in the community but would like to have a paid job in the community (c) like working at their job (d) would like to work someplace other than their current job (e) chose to work at their current job	Participant Questionnaire; Representative Sample; Confidence Interval = 95%	DDDS, DVI and DSAAPD (all PMs)	Continuously and Ongoing (all PMs)	Each of the divisions will serve an active role in correcting identified problems. The divisions will aggregate and analyze the data and will utilize the Pathways workgroup (which includes each operating division and DMMA) to lead cross-program remediation strategies. Delaware will collect data to establish a benchmark against which future improvement will be measured.  Remediation is expected upon detection of issue. Issues are initially discussed among involved parties so as to clearly communicate findings and desired outcomes, followed by a written report reiterating those areas and the date by which issues must be resolved.	Annually

<b>System Improvement:</b> <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
<p>Through reports generated by target group and by the Pathways program as a whole, priorities will be established for systems improvements based upon the following hierarchy. Of paramount importance is to ensure the individual satisfaction of each individual served and to ensure that they are getting needed services. That said, impediments to employment must be addressed swiftly and systematically to ensure the ongoing efficacy of the Pathways program.</p> <ul style="list-style-type: none"> <li>• health and safety of individuals served</li> <li>• services provided in a manner consistent with individuals' plans</li> <li>• employment objectives</li> <li>• others</li> </ul>	<p>The Pathways Workgroup will routinely review aggregated discovery and remediation data to determine areas requiring systems improvement.</p>	<p>Continuously and ongoing</p>	<p>Through data on interventions and through analysis of ongoing discovery data, the workgroup will assess the effectiveness of the system improvement strategies.</p>

## Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. (*Check each that applies, and describe methods and standards to set rates*):

X	<p><b>HCBS Case Management (Employment Navigator)</b></p> <p>Reimbursement is based on a fee schedule that sets a fee for the Employment Navigator provider. The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. Providers of Employment Navigator services are reimbursed on the basis of a payment for a month's provision of service for each participant enrolled for any portion of the month based on reasonable and proper costs for service provision based on federally accepted reimbursement principles (Medicare or OMB A-87 principles) and review of actual costs of operation for the year preceding implementation from a review of financial and statistical reports. Case management services will not be subject to cost settlement. The monthly unit includes all Employment Navigator services utilized for the participant during the entire month.</p> <p>The following list outlines the major allowable cost components to be used in fee development.</p> <ul style="list-style-type: none"> <li>• Staffing Assumptions and Staff Wages</li> <li>• Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)</li> <li>• Staff Productivity Assumptions (e.g., time spent on billable activities)</li> <li>• Program-Related Expenses (e.g., technology related expenses, supplies)</li> <li>• Provider Overhead Expenses</li> </ul> <p>The fee schedule rates will be developed as the total annual provider costs, converted to a monthly unit of service per participant.</p> <p>Billing on a monthly basis is more economical than using 15-minute increments because the amount of bookkeeping is drastically reduced. Employment Navigators must still document all billable activity. For each program year, a projected monthly rate is established, based on reasonable and proper costs of operation pursuant to federally accepted reimbursement principles.</p>
<input type="checkbox"/>	<p><b>HCBS Homemaker</b></p>
<input type="checkbox"/>	<p><b>HCBS Home Health Aide</b></p>
X	<p><b>HCBS Personal Care</b></p> <p>Personal care reimbursement rates will be established as a percentage of the DMMA FFS Home Health Aide agency rate. The state will establish Home Health agency, Personal Care Agency, and self-directed services rates as follows:</p>

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	Home Health Agency Rate as a Percent of DMMA HHA Rate: 84% Personal Care Agencies as a Percent of DMMA HHA Rate: 73% Participant-directed as a Percent of DMMA HHA Rate: 43%, reflecting the removal of reimbursement for administrative functions that will be supported through other means.	
<input type="checkbox"/>	HCBS Adult Day Health	
<input type="checkbox"/>	HCBS Habilitation	
<input type="checkbox"/>	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services	
<input type="checkbox"/>	HCBS Psychosocial Rehabilitation	
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)	
X	Other Services (specify below)	
	Career Exploration and Assessment Rates for Career Exploration and Assessment are based upon established Individual Supported Employment Rates which have been calculated using provider cost modeling using information from independent data sources (as available), through Delaware provider compensation studies, cost data and fees from similar State Medicaid programs may be considered as well,. Total Medicaid allowable costs were tabulated and divided by total direct care staff (job coaches, employment specialists) billable hours. This provided a cost per hour for based on direct care staff hours. The hourly rate will be expressed as a 15 minute billable unit by dividing the hourly rate by four	
	Supported Employment - Individual Rates for Individual Supported Employment have been calculated using provider cost modeling using information from independent data sources (as available), through Delaware provider compensation studies, cost data and fees from similar State Medicaid programs may be considered as well,. Total Medicaid allowable costs were tabulated and divided by total direct care staff (job coaches, employment specialists) billable hours. This provided a cost per hour based on direct care staff hours. The hourly rate will be expressed as a 15 minute billable unit by dividing the hourly rate by four	
	Supported Employment - Small Group Rates for Small Group Supported Employment are based on the rate for Individual Supported Employment, which is a one-to-one staff-to-consumer ratio. The payment rate for the addition of each consumer in the group shall be computed by dividing the payment rate for Individual Supported Employment by the number of participants in the group (up to a maximum of 4) and applying a gross up factor to account for additional incremental costs related to the provision	

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	of group supported employment that would not have been captured in the base rate for Individual Supported Employment. Small Group Supported Employment will be paid in 15 minute billable units.
	<p>Non-Medical Transportation</p> <p>Non-Medical transportation will be implemented utilizing a transportation broker. As such, the state will pay the provider a per member per month (PMPM) payment for the delivery of transportation.</p>
	<p>Benefits Counseling</p> <p>The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), though Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major allowable cost components to be used in fee development.</p> <ul style="list-style-type: none"> <li>• Staffing Assumptions and Staff Wages</li> <li>• Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)</li> <li>• Staff Productivity Assumptions (e.g., time spent on billable activities)</li> <li>• Program Indirect Expenses (e.g., supplies)</li> <li>• Provider Overhead Expenses</li> </ul> <p>The fee schedule rates will be developed as the total hourly provider costs, adjusted for productivity and converted to the applicable unit of service.</p>
	<p>Financial Coaching Plus</p> <p>The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), though Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major allowable cost components to be used in fee development.</p> <ul style="list-style-type: none"> <li>• Staffing Assumptions and Staff Wages</li> <li>• Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)</li> <li>• Staff Productivity Assumptions (e.g., time spent on billable activities)</li> <li>• Program-Related Expenses (e.g., supplies)</li> <li>• Provider Overhead Expenses</li> </ul> <p>The fee schedule rates will be developed as the total hourly provider costs, adjusted for productivity and converted to the applicable unit of service.</p>
	<p>Assistive Technology and Orientation and Mobility Training</p> <p>The fee development methodology is composed of provider cost modeling using information from independent data sources (as available), though Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major allowable components to be used in fee development.</p> <ul style="list-style-type: none"> <li>• Staffing Assumptions and Staff Wages</li> <li>• Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and</li> </ul>

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	<p>workers compensation)</p> <ul style="list-style-type: none"><li>• Staff Productivity Assumptions (e.g., time spent on billable activities)</li><li>• Program-Related Expenses (e.g., supplies)</li><li>• Provider Overhead Expenses</li></ul> <p>The fee schedule rates will be developed as the total hourly provider costs, adjusted for productivity, and converted to the applicable unit of service.</p> <p>Assistive Technology devices are reimbursed based on the cost charged to the general public for the item.</p>
	<p>All rates are published on the Delaware Medical Assistance Program (DMAP) website at <a href="http://www.dmap.state.de.us/downloads/hcpcs.html">www.dmap.state.de.us/downloads/hcpcs.html</a>.</p>